ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for HIPAA 837 Encounter Transactions

Version 5.2
September 2007

Revision History

Date	Version	Description	Author
10/28/2003	1.0	Initial draft	AHCCCS Information Services Division
12/19/2003	2.0	Draft Companion Document for 837 Encounters implementation	AHCCCS Information Services Division
01/29/2004	3.0	Draft Companion Document for 837 Encounters implementation	AHCCCS Information Services Division
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11/14/2005	5.1	Draft Companion Document for 837 Encounters implementation	AHCCCS Information Services Division
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9/24/2007	5.2	NPI and Validator Updates	AHCCCS Information Services Division

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1 Introduction

1.1 Document Purpose

Companion Documents

HIPAA Transaction Companion Documents are available to electronic trading partners (health plans, program contractors, providers, third party processors, and billing services) to clarify information on HIPAA-compliant electronic transactions with AHCCCS. The following Companion Documents are available:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Request and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276 Claim Status Request and 277 Claim Status Response Transactions
- *837 Encounter Transactions*
- 277 Unsolicited Claim Status Transaction (Encounters)

Document Objective

This Encounter Companion Document provides information related to electronic submission of 837 Encounter Transactions to AHCCCS by contracted health plans. Three distinct encounter transaction formats are documented:

- 837 Professional
- 837 Dental
- 837 Institutional

For each of these formats, this Companion Guide assists the health plans in preparing an 837 file that meets the business rules of AHCCCS.

Intended Users

Companion Documents are intended for technical staff of health plans and other entities that are responsible for electronic transaction exchanges.

Relationship to HIPAA Implementation Guides

Companion Documents are intended to supplement HIPAA Implementation Guides. Rules for data format, content, and field values can be found in the Implementation Guides. This Companion Document provides specific information on the fields and values required for transactions that are sent to or received from AHCCCS. Operational information involving connectivity requirements, protocols, and electronic interchange procedures is covered in other documents that are available from the AHCCCS Information Services Division (ISD) Customer Support Center.

Companion Documents are intended to supplement but not to replace the standard Implementation Guides for each HIPAA Transaction Set. Information in Companion Documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is a technical document describing the specific technical and procedural requirements between AHCCCS and its trading partners. It does not supersede either the health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize information conflicts. However, AHCCCS, the Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and outlines the information to be included in the remainder of the document.
Technical Infrastructure	Section 2 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions. The AHCCCS Encounter Manual provides information on file names and procedures used in encounter submission.
Transaction Standards	Section 3 provides information relating to the transaction(s) in this Companion Document including: ▪ General HIPAA transaction standards ▪ Testing criteria and procedures ▪ Front end edits applicable to incoming transactions ▪ Procedures for generating required acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 4 provides specific information relating to the transaction(s) in this Companion Document including: ▪ A statement of the purpose of transaction specifications between AHCCCS and other covered entities ▪ AHCCCS-specific data requirements for the transaction(s) at the data element level Transaction Specifications define in detail how HIPAA Transactions are formatted and populated for exchanges with AHCCCS.

2. Technical Infrastructure and Procedures

2.1 Technical Environment

AHCCCS Data Center Communications Requirements

Trading partners connect to AHCCCS by going from the Internet through a Virtual Private Network (VPN) Tunnel to the AHCCCS File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Cisco Systems Software to establish provider computers as VPN Clients is available from the sources documented in the AHCCCS electronic encounter submission document. Detailed information on FTP and VPN setups also appears in that manual.

Technical Assistance and Help

The AHCCCS ISD Customer Support Center provides technical assistance related to questions about electronic data submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, 837 Encounter Transaction, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

2.2 Directory and File Naming Conventions

FTP Directory Structure

The current structure on the FTP server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance.

FTP\HP Mnemonic\encounter\(IN\OUT)\(prod\test)

- HP Mnemonic – The 3-byte acronym assigned by AHCCCS.
- encounter – The default directory name indicating 837 Encounter Transactions.
- IN – The default directory name indicating inbound data.
- OUT – The default directory name indicating outbound data.
- prod – The default directory name indicating it is the production environment.
- test – The default directory name indicating it is the test environment.

File Naming Conventions

Current FTP Directory file naming conventions are as follows:

1. File name can be any name designated by the Health Plan/Program Contractor, but must not exceed 25 characters.
2. Files cannot be zipped.
3. Files must be placed in folder *hhh*/Encounter/IN/PROD, where *hhh* is the 3 digit Health Plan mnemonic. Please note this is not the same folder for the proprietary files.
4. Files are validated and translated when received, and are not held for verification.
5. Once a file is submitted it is not available for AHCCCSA staff to pull it out of the process. Please be certain that your files are ready for submission before placing them on the FTP site.
6. Files submitted for validation will have an "AHCCCS stamp" appended to the front of the file name. The stamp will be in format of AZ*t*E_HP*xxxxxx_ccyymmddhhmmssss*, where:
   - *t* is I=Institution, P=Professional, D=Dental, N=NCPDP
   - *xxxxxx* is the health plan ID
   - *ccyyymmdd* is date pulled from FTP server
   - *hhmmssss* is time pulled from FTP server
7. Any file received in the folder *hhh*/Encounter/IN/PROD that is not an X12 file will be pulled from the FTP server and archived. No notification will be given and no further processing will occur. Please

be careful to drop your files to the correct folder, as pulling these files from archive to confirm your error is a manual process that will delay your submissions.

8. File names will be displayed in the system as follows:
   - After validation, files will be viewed in Transaction Insight (TI) named as AZ*t*E_HP*xxxxxx_ccyymmddhhmmssss*_originalfilename.edi
   - Acknowledgement files (i.e., 997, 824, TA1) on the FTP server will be named as AZ*t*E_HP*xxxxxx_ccyymmddhhmmssss*_originalfilename.(997,824, or TA1)
   - After translation and importation to PMMIS (EC552 HIPAA Transmission Summary) files will be named as "original file name"
9. The GS02 segment must contain the 6 digit Health Plan ID followed by the 3 digit TSN.

For more information on Incoming and Outgoing file formats, reference the Encounter Manual available on the AHCCCS website (http://www.ahcccs.state.az.us/Publications/GuidesManuals/EncounterManual/default.asp).

3. Transaction Standards

3.1 General Information

HIPAA Requirements

HIPAA standards are specified in Implementation Guides for each transaction set and in authorized Addenda. The second draft Addenda Documents for the three types of 837 Transactions have been published in final form in February 2003. In this Companion Document, AHCCCS uses 837 Transactions as modified by final Addenda. For X12 Transactions, an overview of requirements specific to each transaction can be found in each Implementation Guide. Implementation Guides contain information related to:

- The format and content of interchanges and functional groups of transactions
- Code sets and values authorized for use in the transaction

For encounters, this Companion Document, in combination with the Implementation Guide, tells how to prepare data for submission to AHCCCS.

Size of Transmissions/ Batches

Transmission sizes are limited based on the number of segments/records recommended by HIPAA standards. There is no AHCCCS limit on file size for electronic encounter submission. HIPAA recommendations for the maximum file size of each transaction set are specified in the Implementation Guide and its authorized Addenda.

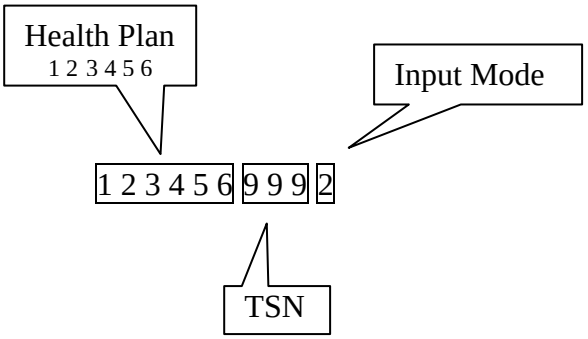
For the 837 Transaction, the Implementation Guide's recommendation is for a maximum of 5,000 CLM Claim Information Segments, generally equivalent to 5,000 claims or encounters. This does not mean that encounter submitters are limited to 5,000 encounters per submission. Multiple 837 Encounter Transactions of 5,000 encounters each can be submitted within a functional group and transmission.

AHCCCS will accept files with a maximum physical file size of 200 megabytes. The total maximum number of encounters allowed in one interchange will be 250,000 regardless of the number of transactions sets (ST/SE). The total maximum number of encounters allowed in one transaction set (ST/SE) is 50,000, preferably 5,000 as suggested in the Implementation Guide.

Health Plan ID(s) in the 837 Encounter

Health plan identifications in the 837 encounter must contain the Health Plan ID, Transmission Submitter Number (TSN), and Input Mode for the entire interchange. The following is the expected layout, example and where this ID appears:

Health Plan ID		9(6)
Transmission Submitter Number	9(3)	
Input Mode	9(1)	
		"2" Adjudicated Encounter
		"6" Denied Encounter



Required as the Submitter

1000A Submitter Name
NM109 – Submitter Primary Identification Number

There will be one 2320 Other Subscriber Information Loop that represents the Health Plan

2330B Other Payer Name
NM109 – Other Payer Primary Identifier

There will be one 2430 Line Adjudication Loop that details the Health Plan Payment/Denial

2430 Line Adjudication
SVD01 – Payer Identifier

3.2 Edits for Encounter Transactions

Overview of the Syntactical Edit Process

Edits performed by AHCCCS on 837 Encounter Transactions ensure that incoming transactions comply with the standards documented in the transaction's HIPAA Implementation Guide. Only 837 transactions that have passed validation edits can have their encounters translated and adjudicated. The validation edits are prior to and in addition to edits performed by PMMIS. AHCCCS processes and procedures for resolution of encounters pended by PMMIS remain unchanged.

AHCCCS uses the 997 Functional Acknowledgement Transaction to acknowledge each functional group of 837 Transactions that has passed validation translator edits. AHCCCS uses the 824 Implementation Guide Reporting Transaction to inform 837 submitters of "syntactical" problems.

Four types of edits (in addition to preliminary edits that involve only ISA/IEA outer envelopes) are reported on 824 Transactions. They are:

1. Integrity Edits
   This kind of edit validates the basic syntactical integrity of the incoming EDI file.

2. Implementation Guide-Requirements Edits
   This kind of edit involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Edits
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Edits
   Edits to validate inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must be present).

In addition to carrying error codes, the 824 Transaction shows the relative location of erroneous data structures with error position designators. For a large transaction, each of the generic edit code values can be repeated in many code to element combinations.

3.3 Data Interchange Conventions

Overview of Data Interchange

When receiving 837 Encounter Transactions from health plans, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 837 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of Implementation Guides.

Transaction Specifications that say how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes appear in the table beginning on the next page. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Sender and Receiver Identification Numbers in ISA and GS Segments are assigned by AHCCCS.

Outer Envelope Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Bytes	00	No Authorization Information Present
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 bytes	00	No Security Information present
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 bytes	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 bytes		The Interchange Sender ID consists of a 3-byte acronym assigned by AHCCCS followed by the submitter's Tax ID.
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 bytes	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 bytes		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number ("AHCCCS866004791")
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 bytes		ISA13 must be unique within all transmissions (i.e., files) submitted to AHCCCS by the same entity. AHCCCS tracks this number to guard against duplicate file submissions. ISA13 must also be identical to the control number in Interchange Trailer element IEA02.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA14	ACKNOWLEDGEMENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	Interchange Acknowledgement Requested AHCCCS returns a TA1 Application Acknowledgement to the encounter submitter if there are errors in the outer envelope.
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character		Trading partners can use any conventions they wish to establish separators or delimiters within transactions. The AHCCCS translator interprets separator values from their use in ISA Segments and in ISA16. Trading partners are free to adopt the values used by AHCCCS on outgoing transactions (see below). Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions and are available to encounter submitters: Segment Delimiter - “~’ (tilde – hexadecimal value X”7E”) Element Delimiter - “{“ (left rounded bracket – hexadecimal value X”7B”) Composite Component Delimiter (ISA16) - “|” (pipe – hexadecimal value X”7C”) These values are used because they are not likely to occur within transaction data.

GS/GE FUNCTIONAL GROUP ENVELOPE SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		The Application Sender's Code consists of the 6 digit AHCCCS Health Plan ID followed by the 3 digit TSN.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number ("AHCCCS866004791")	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender

4. Transaction Specifications

4.1 Transaction Specifications

Purpose

Transaction specifications are designed, in combination with the HIPAA Implementation Guides, to identify data to be transmitted between particular trading partners and to specify its type and format. This information supplements the requirements in HIPAA Transaction Implementation Guides. Data structures that are fully covered by the HIPAA Implementation Guide are not mentioned in this section.

Only transaction data with submission requirements specific to AHCCCS encounters is included. For example, the 2320 Other Subscriber Information Loop and the loops within it are used on AHCCCS X12 encounters to report, on one iteration, health plan adjudication information and, on additional iterations, adjudication information from other carriers that also contributed to payment. This AHCCCS usage is not discussed explicitly in the 837 Professional Implementation Guide but is covered in this Companion Document.

Relationship to HIPAA Implementation Guides

Transaction specifications are intended to supplement the data in the Implementation Guides for each transaction set with specific information pertaining to the trading partners using the transaction set.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

4.2 Encounter Transaction Specifications – Professional 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purpose of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications described in this section apply only to 837 Professional Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Professional 837 Encounter Transaction Specifications that are not specific to an individual data element are discussed below.

- All Professional 837 Encounter Loops, Segments, and Elements are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to medical providers by the submitting health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  One iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Professional 837 Transactions is always for the submitting health plan and is always required. Up to nine additional situational iterations of the 2320 Loop are available for additional other payers.

Transaction Specifications Table

The Professional 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	837	Health Care Claim
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set functional group		An identification number for the 837 Professional transaction that is unique within the transaction's functional group. As implemented by AHCCCS, 837 Professional Transactions must occur within functional groups defined by ASC X12 GS/GE envelopes. The value in ST02 must be repeated in the SE02 Element at the end of the transaction.
N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	0019	Information Source, Subscriber, Dependent The "0019" values is required in the 837 Professional Implementation Guide even when Dependent Segments are not present.
N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	00 18	Original Reissue BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. ORIGINAL: Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.
N/A	BHT	BHT03	Originator Application Transaction Number	Trace or control number assigned by the originator of the transaction		A Transaction Identification Number, or inventory file number, assigned by the 837 Professional requester. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.
N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the 837 Professional Transaction is created in CCYYMMDD format.
N/A	BHT	BHT05	Transaction Set Creation Time	Time file is created for transmission		The time at which the transaction is created in HHMMSS format
N/A	BHT	BHT06	Claim or Encounter Identifier	Code specifying the type of transaction	RP	Reporting RP is used when the entire ST-SE envelope contains encounters.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode (“2” [Adjudicated Encounter] or “6” [Denied Encounter]).
1000A	PER	PER01	Contact Function Code	Code qualifying the major duty or responsibility of the person or group named.	IC	Information Contact for BBA (Balanced Budget Act) Data Certification Process.
1000A	PER	PER02	Submitter Contact Name	The name of the person who is attesting to the file.		The name of the person who is attesting to the file. 60 character maximum.
1000A	PER	PER03	Communication Number Qualifier	Code qualifying the communications number.	ED	Electronic Data Interchange Access Number
1000A	PER	PER04	Communication Number	The file certification.	TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE	The file certification. 80 character maximum.
1000A	PER	PER05	Communication Number Qualifier	Code qualifying the communications number.	EM	Electronic Mail
1000A	PER	PER06	Communication Number	The email address of the person who is attesting to the file.		The email address of the person who is attesting to the file which must be compliant with BBA specifications. 80 character maximum.
1000A	PER	PER07	Communication Number Qualifier	Code qualifying the communications number.	TE	Telephone Number
1000A	PER	PER08	Communication Number	The telephone number of the person certifying the file.		The telephone number of the person certifying the file including country or area code when applicable.
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	The AHCCCS Federal Tax ID
2010AA	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	 24 34 XX 	The qualifier for the Federal Tax ID used by atypical service providers. Employer’s Identification Number Social Security Number The qualifier for the NPI used by health care service providers. National Provider Identifier Group Billers enter the group’s information.
2010AA	NM1	NM109	Billing Provider Identifier	Primary identification for the billing provider		The billing provider’s EIN, SSN or NPI.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2010AA	REF	REF02	Billing Provider Additional Identifier	Secondary identification for the billing provider		Atypical Service Providers For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. Health Care Service Providers This REF02 Provider ID field should always be populated, both when the Billing Provider and the Rendering Provider are the same and when they are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2010AB	NM1	NM109	Pay-to Provider Identifier	Primary identification for the pay-to provider		The Pay-To Entity's EIN, SSN or NPI
2010AB	REF	REF02	Pay-to Provider Additional Identifier	Secondary identification for the pay-to provider		The Pay-To Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
2300	CN1	CN101	Contract Type Code	Code identifying a contract type	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other
2300	AMT	AMT02	Total Purchased Service Amount	Amount of charges associated with the claim attributable to purchased services		Required if there are purchased service components to an encounter.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Required for replacement and void encounters (CLM05-3 = "7" or "8").
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		For replacement and void encounters (CLM05-3 = "7" or "8"), the AHCCCS Claim Reference Number (CRN) of the prior encounter being replaced or voided.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	EA	Medical Record Number
2300	REF	REF02	Medical Record Number Reference Identification	Medical record number		The Medical Record Number assigned to the AHCCCS recipient by the servicing organization
2310B	NM1	NM109	Rendering Provider Identifier	Primary identification for the rendering provider		The Service Provider's EIN, SSN or NPI

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310B	REF	REF02	Rendering Provider Secondary Identifier	Secondary identification for the rendering provider		Atypical Service Providers For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. Health Care Service Providers This REF02 Provider ID field should always be populated, both when the Billing Provider and the Rendering Provider are the same and when they are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the identifies the health plan's AHCCCS ID, TSN and Input Mode. In subsequent 2320 Loops, the Subscriber ID assigned by the other payer.
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, the health plan's AHCCCS ID, TSN, and Input Mode. In additional 2320 Loops, any identification number assigned by the health plan to the other payer in this required element. AHCCCS will not perform validity edits on this identifier for payers other than contracted health plans.
2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	F8	Original Reference Number
2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan or other payer's Claim Number for the claim that generated this encounter.

4.3 Encounter Transaction Specifications – Dental 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purpose of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications in this section apply only to 837 Dental Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Dental 837 Encounter Transaction specifications that are not specific to a particular data element are discussed below.

- All Dental 837 Encounter Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to providers by the submitting health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  The health plan iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Dental 837 Transactions is always for the sending health plan. A health plan loop is required. Up to nine situational iterations of the 2320 Loop are available for additional other payers.

- Although the Dental 837 Transaction can be used to pre-approve dental

services, AHCCCS does not use it in this manner and does not expect pre-approval data on dental encounters.

Transaction Specifications Table

The Dental 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set functional group		An identification number for the 837 Dental transaction that is unique within the transaction's functional group. As implemented by AHCCCS, 837 Dental Transactions must occur within functional groups defined by ASC X12 GS/GE envelopes. The value in ST02 must be repeated in the SE02 Element at the end of the transaction.
N/A	BHT	BHT03	Originator Application Transaction Number	Trace or control number assigned by the originator of the transaction		A Transaction Identification Number, or inventory file number, assigned by the 837 Dental requester. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.
N/A	BHT	BHT06	Claim or Encounter Identifier	Code specifying the type of transaction	RP	Reporting RP is used when the entire ST-SE envelope contains encounters.
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode ("2" [Adjudicated Encounter] or "6" [Denied Encounter]).
1000A	PER	PER01	Contact Function Code	Code qualifying the major duty or responsibility of the person or group named.	IC	Information Contact for BBA (Balanced Budget Act) Data Certification Process.
1000A	PER	PER02	Submitter Contact Name	The name of the person who is attesting to the file.		The name of the person who is attesting to the file. 60 character maximum.
1000A	PER	PER03	Communication Number Qualifier	Code qualifying the communications number.	ED	Electronic Data Interchange Access Number
1000A	PER	PER04	Communication Number	The file certification.	TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE	The file certification. 80 character maximum.
1000A	PER	PER05	Communication Number Qualifier	Code qualifying the communications number.	EM	Electronic Mail
1000A	PER	PER06	Communication Number	The email address of the person who is attesting to the file.		The email address of the person who is attesting to the file which must be compliant with BBA specifications. 80 character maximum.
1000A	PER	PER07	Communication Number Qualifier	Code qualifying the communications number.	TE	Telephone Number
1000A	PER	PER08	Communication Number	The telephone number of the person certifying the file.		The telephone number of the person certifying the file including country or area code when applicable.
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	AHCCCS Federal Tax ID

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2010AA	NM1	NM109	Billing Provider Identifier	Primary identification for the billing provider		The Billing Entity's EIN, SSN or NPI
2010AA	REF	REF02	Billing Provider Additional Identifier	Secondary identification for the billing provider		Atypical Service Providers For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. Health Care Service Providers This REF02 Provider ID field should always be populated, both when the Billing Provider and the Rendering Provider are the same and when they are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2010AB	NM1	NM109	Pay-to Provider Identifier	Primary identification for the pay-to provider		The Pay-To Entity's EIN, SSN or NPI
2010AB	REF	REF02	Pay-to Provider Additional Identifier	Secondary identification for the pay-to provider		The Pay-To Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
2300	DN2	DN202	Tooth Status Code	Code specifying the status of the tooth	E I M	Tooth Status Code To be extracted Impacted Missing
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Required for replacement and void encounters (CLM05-3 = "7" or "8").
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		For replacement and void encounters, the AHCCCS Claim Reference Number (CRN) of the prior encounter being replaced or voided.
2310B	NM1	NM109	Rendering Provider Identifier	Primary identification for the rendering provider		The Service Provider's EIN, SSN or NPI
2310B	REF	REF02	Rendering Provider Secondary Identifier	Secondary identification for the rendering provider		Atypical Service Providers For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. Health Care Service Providers This REF02 Provider ID field should always be populated, both when the Billing Provider and the Rendering Provider are the same and when they are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the member's AHCCCS ID. In additional 2320 Loops, the Subscriber ID assigned by the other payer.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, the identifies the health plan's AHCCCS ID, TSN and Input Mode. In additional 2320 Loops, any identification number assigned by the health plan to the other payer in this required element. AHCCCS will not perform validity edits on this identifier.
2230B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	F8	Original Reference Number
2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan or other payer's Claim Number for the claim.
2330B	REF	REF02	Other Payer Claim Adjustment Indicator	Indication that the claim is an adjustment of a previously adjudicated claim		Health Plan's Indication of Claim Re-Adjudication
2420B	NM1	NM109	Other Payer Referral Number	The non-destination (COB) payer's service line level referral number		The other payer's identification number. It must be the same as a payer's ID Number in a claim level 2330B Loop.

4.4 Encounter Transaction Specifications – Institutional 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purpose of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications in this section apply only to 837 Institutional Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Institutional 837 Encounter Transaction Specifications that are not specific to an individual data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Institutional 837 Encounter Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to medical providers by the sending health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  The health plan iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Institutional 837 Transactions is always for the sending health plan. A health plan loop is required. Up to nine situational iterations of the 2320 Loop are available for additional other payers.

Transaction Specifications Table

The Institutional 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element's name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set functional group		An identification number for the 837 Institutional transaction that is unique within the transaction's functional group. As implemented by AHCCCS, 837 Institutional Transactions must occur within functional groups defined by ASC X12 GS/GE envelopes. The value in ST02 must be repeated in the SE02 Element at the end of the transaction.
N/A	BHT	BHT03	Originator Application Transaction Number	Trace or control number assigned by the originator of the transaction		A Transaction Identification Number, or inventory file number, assigned by the 837 Institutional requester. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.
N/A	BHT	BHT06	Claim or Encounter Identifier	Code specifying the type of transaction	RP	Reporting RP is used when the entire ST-SE envelope contains encounters.
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode ("2" [Adjudicated Encounter] or "6" [Denied Encounter]).
1000A	PER	PER01	Contact Function Code	Code qualifying the major duty or responsibility of the person or group named.	IC	Information Contact for BBA (Balanced Budget Act) Data Certification Process.
1000A	PER	PER02	Submitter Contact Name	The name of the person who is attesting to the file.		The name of the person who is attesting to the file. 60 character maximum.
1000A	PER	PER03	Communication Number Qualifier	Code qualifying the communications number.	ED	Electronic Data Interchange Access Number
1000A	PER	PER04	Communication Number	The file certification.	TOMYKNOWLEDGEINFORMATIONANDBELIEFTHEDATAINTHISFILEISACCURATECOMPLETEANDTRUE	The file certification. 80 character maximum.
1000A	PER	PER05	Communication Number Qualifier	Code qualifying the communications number.	EM	Electronic Mail
1000A	PER	PER06	Communication Number	The email address of the person who is attesting to the file.		The email address of the person who is attesting to the file which must be compliant with BBA specifications. 80 character maximum.
1000A	PER	PER07	Communication Number Qualifier	Code qualifying the communications number.	TE	Telephone Number
1000A	PER	PER08	Communication Number	The telephone number of the person certifying the file.		The telephone number of the person certifying the file including country or area code when applicable.
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
1000B	NM1	NM108	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query	46	Electronic Transmitter Identification Number (ETIN)

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	AHCCCS Federal Tax ID
2010AA	NM1	NM109	Billing Provider Identifier	Primary identification for the billing provider		The Billing Entity's EIN, SSN or NPI
2010AA	REF	REF02	Billing Provider Additional Identifier	Secondary identification for the billing provider		Atypical Service Providers For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. Health Care Service Providers This REF02 Provider ID field should always be populated, both when the Billing Provider and the Rendering Provider are the same and when they are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2010AB	NM1	NM109	Pay-to Provider Identifier	Primary identification for the pay-to provider		The Pay-To Entity's EIN, SSN or NPI
2010AB	REF	REF02	Pay-To Provider Additional Identifier	Secondary identification for the pay-to provider		The Pay-To Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
2300	CN1	CN101	Contract Type Code	Code identifying a contract type	01 02 03 04 05 06 09	Diagnosis Related Group (DRG) Per Diem Variable Per Diem Flat Capitated Percent Other Enter the value that best describes the facility's relationship to the health plan.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number This REF Segment is required on replacement and void claims. The Original Reference Number is the AHCCCS CRN assigned to the encounter being replaced or voided (when CLM05-3 = "7" or "8").
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		The AHCCCS assigned Claim Reference Number (CRN) for the encounter being replaced or voided.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	EA	Medical Record Number
2300	REF	REF02	Medical Record Number Reference Identification	Medical record number		The Medical Record Number assigned to the AHCCCS recipient by the servicing organization
2310E	NM1	NM109	Service Facility Primary Identifier	Primary identification for the service provider		The Service Provider's EIN, SSN or NPI

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2310E	REF	REF02	Service Facility Secondary Identifier	Secondary identification for the service provider		Atypical Service Providers For all claims except Medicare crossovers, the AHCCCS ID and Location Code of the rendering provider. Submit this number with two leading zeros. The format is 00aaaaaall when aaaaaa is the AHCCCS Provider ID and ll the Location Code. Health Care Service Providers This REF02 Provider ID field should always be populated, both when the Billing Provider and the Rendering Provider are the same and when they are different. On Medicare crossovers, use the Medicare Provider ID without leading zeros.
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the member's AHCCCS ID. In subsequent 2320 Loops, the Subscriber ID assigned by the other payer.
2330B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	PI	Payer identification
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, this identifies the health plan's AHCCCS ID, TSN, and Input Mode. In subsequent 2320 Loops, any identification number assigned to the other payer.
2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Use code F8 to indicate the payer's claim number assigned to this claim by the health plan or other payer referenced in this iteration of Loop 2330B.
2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan's or other carrier's claim control number for the claim the resulted in this encounter. This is not the CRN that AHCCCS assigns to the encounter.